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28436

OCCLUDED ARTERY TRIAL (OAT)
Consent For Long-Term Follow-up Form

Please Use Black Pen To Fill Out Form.

Patient's ID Number: ___ - ___ Letter Code: ___ Correction ○

Date Form Completed: ___ – ___ – ____ (mmm dd yyyy) Sequence Number: seqno

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1. Were you able to contact patient for consent for OAT Long-Term Follow up? Yes ○ No ○ contct70

If Yes, complete remainder of form.
If No, skip to signature. This patient will not be contacted for long-term follow up.

A. Has HIPAA authorization been obtained? ○ Yes ○ No ○ NA hippa70

Non U.S. clinical sites, answer NA

If Yes or N/A, complete remainder of form.
If No, skip to signature.

2. Date patient contacted: ___ – contdt – ____ (mmm dd yyyy)

3. Did patient give consent to participate in the OAT Long-Term Follow up? Yes ○ No ○ consnt70

If Yes, answer Item 4.
If No, skip to signature. This patient will not be contacted for long-term follow up.

4. Will the patient's current OAT Clinical Site complete the long-term follow up? Yes ○ No ○ currsite

If No, complete the Transfer of Follow-up Form (OAT Form 60).

Signature: _____ ___ - ___ OAT Staff Number

FAX to MMRI

e-mail to MMRI